GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 1, 2023

Deborah Hampton
Church of Christ Assisted Living
23621 15 Mile Road
Clinton Township, MI 48035

RE: License #: AH500243182
Investigation #: 2023A1027056
Church of Christ Assisted Living

Dear Ms. Hampton:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH500243182
Investigation #:	2023A1027056
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/03/2023
Report Due Date:	06/03/2023
Licensee Name:	Church of Christ Assisted Living
Licensee Address:	23575 15 Mile Rd. Clinton Township, MI 48035
Licensee Telephone #:	(586) 791-2470
Authorized Representative/ Administrator:	Deborah Hampton
Name of Facility:	Church of Christ Assisted Living
Facility Address:	23621 15 Mile Road Clinton Township, MI 48035
Facility Telephone #:	(586) 285-6230
Original Issuance Date:	04/26/2002
License Status:	REGULAR
Effective Date:	07/15/2022
Expiration Date:	07/14/2023
Capacity:	138
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medications as prescribed.	Yes
Resident A's medications were not observed by staff when administered to him.	Yes
Resident A lacked care and laundry services.	Yes
Resident A lacked medical services. The facility front desk lacked staff. Resident A's family were unable to view Resident A's medication administration records.	No
Additional Findings	No

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A1027056
04/03/2023	Special Investigation Initiated - Letter email sent to complainant requesting additional information.
04/03/2023	Contact - Document Received Email received from complainant with additional information
04/06/2023	Contact - Document Received Email received from complainant's family with additional information
04/17/2023	Inspection Completed On-site
04/24/2023	Contact - Document Received Email received from Ms. Hampton with additional information and documentation
04/27/2023	Contact - Document Sent Email sent to Ms. Hampton requesting additional documentation
04/27/2023	Contact - Document Received Email received from Ms. Hampton with requested information
04/28/2023	Contact - Document Sent

	Email sent to Ms. Hampton requesting Resident A's service plan
05/01/2023	Inspection Completed-BCAL Sub. Compliance
05/03/2023	Contact – Document Received Email received from Ms. Hampton with requested documentation
05/19/2023	Exit Conference Conducted by telephone with authorized representative Ms. Hampton

ALLEGATION:

Resident A did not receive his medications as prescribed.

INVESTIGATION:

On 4/3/2023, the Department received a complaint through the online complaint system which read Resident A resided at the facility from 12/9/2022 to 3/4/2023. The complaint read there were two instances when Resident A had not received the proper quantity of medication and per the facility, the medications were “out of stock.” The complaint read on 2/28/2023 Resident A had not received his medications.

On 4/17/2023, I conducted an on-site inspection at the facility. I interviewed administrator and authorized representative Deborah Hampton. Ms. Hampton stated there was an issue identified with OneCare Pharmacy in which two residents’ medications, including Resident A, were not stocked with a full supply for the month. Ms. Hampton stated after that time, the medication carts were audited by Employee #1 weekly.

While on-site, I interviewed Employee #1 who stated the shortage of medications by OneCare Pharmacy was identified in January 2023. Employee #1 stated they initiated a procedure of reviewing all medications in the medication carts to identify which were short then notified the pharmacy. Employee #1 stated she reviewed the medications on the 13th of every month and medications were delivered from OneCare Pharmacy on the 15th.

While on-site, I interviewed Employee #2 who stated Resident A’s medications were available in the medication cart for his medication pass. Employee #2 stated Resident A was alert and orientated in which he could inform staff if he had not received his medications.

While on-site, I interviewed Employee #3 whose statements were consistent with Employee #2.

I reviewed Resident A's service plan dated 12/9/2022 which read in part facility staff were responsible for his medication administration.

I reviewed Resident A's medication administration records (MARs) dated December 9, 2022, through March 4, 2023, which read staff initialed the medications as administered or documented, per the chart codes, as to why the medication was not administered. The December 2022 MAR read one or more medications were left blank on the following dates: 12/22/2022 and 12/23/2022. The January 2023 MAR read one or more medications were left blank on the following dates on: 1/27/2023. The January 2023 MAR read Gabapentin 400 mg, give one capsule orally one time a day for pain at 2100 [9:00 PM]. The MAR read Gabapentin was held from 1/1/20223 0000 [12:00 midnight] to 1/2/2023 0921 [9:21 AM]. The MAR read Gabapentin was administered from 1/2/2023 to 1/11/2023, 1/19/2023, 1/21/2022; however, some staff documented the medication as "9" which corresponded to "other/see nurses notes" on the following dates 1/12/2023 to 1/18/2023, 1/20/2023, and 1/22/2023 to 1/25/2023. The MAR read Gabapentin was discontinued on 1/25/2023. The February 2023 MAR read one or more medications were left blank on the following dates: 2/1/2023, 2/10/2023, 2/26/2023, 2/27/2023, and 2/28/2023. The March 2023 MAR read Resident A's medications were initialed as administered or documented that he was absent from the home, as well as to see the nurse notes.

I reviewed a staff communication note dated 1/25/2023 which read in part Resident A's Gabapentin 400 mg was out.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
For Reference: **R 325.1901**	**Definitions.** **Rule 1. As used in these rules:**
	(n) "Medication management" means assistance with the acquisition and administration of a resident's prescribed medication.

ANALYSIS:	Interviews with staff revealed the facility was responsible for administration of Resident A's medications. Review of Resident A's MARs revealed there were several instances when dates were left blank in which it could not be determined if his medications were administered or not. Additionally, there were instances when Resident A's medication was documented as not administered for other reasons in which per the staff's communication notes was for being out of stock. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were not observed by staff when administered to him.

INVESTIGATION:

On 4/3/2023, the Department received a complaint through the online complaint system which read there were three instances of a staff not witnessing Resident A consume his medications. The complaint read on 2/27/2023, Resident A's spouse and a visitor observed staff had not witnessed Resident A consume his medications.

On 4/17/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Hampton who stated Employee #4 was terminated for not administering medications per the facility policy.

While on-site, I interviewed Employee #1 who statements were consistent with Ms. Hampton.

I reviewed Resident A's MARs from dated December 9, 2022, through March 4, 2023, which read Employees #2, #3 and #4 had administered Resident A's medications.

While on-site, I interviewed Employees #2 and #3 who both stated when administering residents' medications, they observed each resident consume their medications, including Resident A.

While on-site, I reviewed Employee #4's file which read consistent with statements from Ms. Hampton in which she was terminated on 4/11/2023. I reviewed Employee #4's training records which read in part she had completed the medication training test on 7/28/2022 and medication competency training on 7/27/2022; however, it was not signed and dated by Employee #4 as completed.

While on-site, I reviewed Employees #2 and #3's medication training records. Employee #2's training records read in part she completed the medication training test on 4/14/2022 and medication competency training on 5/25/2022, which was signed by her and the training staff member. Employee #3's training records read in part she completed the medication training test on 8/26/2022 and medication competency training on 9/14/2022, which was signed by her and the training staff member.

I reviewed the facility's education titled *Medication Management: Training Program* which read in part:

> *"Medications should be signed out only AFTER the medications have been given to the resident and they have been observed taking the medications."*

I reviewed the facility's education titled *Medication Pass Competency Audit* which read in part:

> *"Oral medications – hands resident medications as ordered, gives water or drink to swallow, observes resident take medication."*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(a) Be trained in the proper handling and administration of the prescribed medication**
ANALYSIS:	Review of facility records revealed staff were trained to observe the resident consume their medications. Review of employee training records revealed that Employee #4's competency training was incomplete in which it could not be determined if she was competent in medication administration, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A lacked care and laundry services.

INVESTIGATION:

On 4/3/2023, the Department received a complaint through the online complaint system which read Resident A lacked showers twice weekly with the most recent date 2/26/2023. The complaint read Resident A's catheter bag was not properly cleaned on 2/25/2023. The complaint read Resident A's wastebaskets contained urine and urine-soaked clothing. The complaint read Resident A's laundry was not completed promptly.

On 4/17/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Hampton who stated the facility had one laundry staff person worked Monday through Friday each week. Ms. Hampton stated the laundry staff person was off work for approximately two weeks at the end of February 2023 with COVID-19 in which maintenance and concierge staff filled in completing laundry duties. Ms. Hampton stated residents were offered two loads of laundry weekly. Ms. Hampton stated recently the facility hired a staff person to assist with laundry services. Ms. Hampton stated there was designated staff person for housekeeping services, two staff persons designated for laundry services and a maintenance director. Ms. Hampton stated staff were also trained to complete resident's laundry if needed.

While on-site, I interviewed Employee #1 who stated Resident A was alert and orientated in which he could verbalize his needs. Employee #1 stated Resident A preferred showers from an aide at his home care agency in which she came to the facility a few times, but then her services were discontinued. Employee #1 stated Resident A sometimes declined showers in which his spouse was notified. Employee #1 stated staff were trained on how to clean around the catheter and tubing, as well as empty the catheter bag. Employee #1 stated staff assisted Resident A with his suprapubic catheter care. Employee #1 stated Resident A was hospitalized from 12/28/2022 to 1/1/2023 and 2/14/2023 to 2/17/2023 during his stay at the facility.

While on-site, I interviewed Employees #2 and #3 whose statements were consistent with Employee #1.

I reviewed Resident A's admission contract dated 12/9/2022 which read consistent with Ms. Hampton's interview.

I reviewed Resident A's history and physical dated 12/20/2022 which read consistent with staff interviews.

I reviewed Resident A's service plan dated 12/9/2022 which read in part he was able to communicate his needs. The plan read in part he required one person assist with shower/bathing, specifically washing his hair and applying shampoo, on Sundays and Thursdays. The plan read in part he had a suprapubic catheter and required assistance emptying the bag as needed, as well as washing it with mild soap and water daily. The plan read in part Resident A's laundry was to be completed by the facility.

I reviewed Resident A's shower sheets which read he had received showers on the following dates 12/12/2023, 1/15/2023, 1/19/2023, 1/26/2023, 2/19/2023, and 3/2/2023. Shower sheet dated 2/16/2023 read Resident A was at the hospital.

I reviewed the facility's physician communication log from December 2022 through March 2023. Log entry dated 12/30/2022 read Resident A went to the hospital on 12/28/2022 for blood in his urine.

I reviewed the facility's resident aide orientation competency training which read in part staff were trained how to properly clean around the catheter site, empty the catheter bag using good infection control and knowing what to report to the supervisor.

I reviewed the facility's laundry procedure which read consistent with statements from Ms. Hampton. The procedure read in part, "if a resident has an accident and needs laundry done that should be done on the shift that it occurs on, folded, and put away."

I reviewed the facility's "*RA Check List*" which read in part to complete assigned laundry, fold, and put away. The check list read in part to never leave laundry soiled with "BM" [bowel movement], urine or vomit in the hamper.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.

ANALYSIS:	Review of Resident A's medical records revealed Resident A was alert and orientated and required assistance with his personal care including showers and his suprapubic catheter. Review of Resident A's service plan revealed he was to receive showers twice weekly. Review of Resident A's shower sheets read inconsistent with the service plan nor minimally once weekly. Although there was insufficient evidence to support lack of catheter care on a specific date or lack of laundry services, Resident A did not always receive care consistent with his service plan, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A lacked medical services. The front desk lacked staff. Resident A's family were unable to view Resident A's medication administration records.

INVESTIGATION:

On 4/3/2023, the Department received a complaint through the online complaint system which read Resident A had significant leg pain in December 2022 which was not addressed for over a week. The complaint read Resident A had swelling in his lower legs that was not addressed for four days in January 2023. The complaint read there were no staff at the front desk and visitors were not signing in or out. The complaint read family requested to view Resident A's MARs on 3/4/2023 to review medication administration on 2/28/2023, however they were unable to view them.

While on-site, I interviewed Ms. Hampton who stated the front desk was managed by concierge staff Monday through Friday 8:00 AM to 7:15 PM, and Saturday and Sunday 9:00 AM to 6:30 PM. Ms. Hampton stated there was a 32-hour concierge staff position open which had not been filled yet, so there was not always a staff person during those times. Ms. Hampton stated upon admission to the facility, residents and their families were informed of how to enter the facility which included the process of signing in/out on the visitor log and shown the sign with shift supervisor's phone number at the front desk, as well as provided a list of facility phone numbers. Ms. Hampton stated there was signage outside on the front entrance doors with shift supervisor's phone number as well, and a call button with speaker. Ms. Hampton stated there was a designated shift supervisor on each shift, as well as manager on duty. Ms. Hampton stated Resident A's spouse could request medical records from her or Employee #1 in which would have been provided.

While on-site, I interviewed Employees #1 whose statements were consistent with Ms. Hampton. Employee #1 stated Resident A's physician visited every Tuesday and his nurse practitioner visited every Thursday. Employee #1 stated either the

physician or nurse practitioner were always available in which for non-emergent communication, staff communicated resident's concerns or medications changes in the physician communication log binder. Employee #1 stated if a resident had a concern and the healthcare professional was not rounding that day, that staff could call their office and obtain orders the same day. Employee #1 stated Resident A was prescribed medications Gabapentin and Methocarbamol for pain in which were changed by the physician, per his or his family's request, several times during his stay. Additionally, Employee #1 stated she had not received a request for medical records for Resident A. Employee #1 stated she could print or email the medical records upon request.

While on-site, I reviewed a sign on the facility's front desk which read "Be Back Soon, Concierge has stepped away. If you need immediate assistance. Please call 586-551-6427. Thank You!"

While on-site, I observed a sign on the outside facility front entrance door which read consistent with statements from Ms. Hampton, as well as the sign at the front desk.

I reviewed Resident A's admission contract dated 12/9/2022 which read in Resident A's spouse was his "Responsible Party." The contract read in part only "Responsible Party individuals" will have access to records. The contract read in part all guests were to register at the Concierge desk in the Visitor's Log.

I reviewed Resident A's physician orders which read in part the following medication orders were changed Methocarbamol on 12/20/2022 and 12/22/2022, Gabapentin on 12/20/2022, 12/27/2022, 12/28/2022, and 12/29/2022, Acetaminophen on12/20/2022, and Baclofen on 12/27/2022.

I reviewed the facility's physician communication log from December 2022 through March 2023 which read consistent with statements from Ms. Hampton and Employee #1. Log entries dated 12/15/2022 and 12/19/2022 read to change Resident A's medication doses for Methocarbamol and Gabapentin consecutively. Log entry dated 1/15/2023 read Resident A had bilateral feet edema. The log read his spouse stated to staff that his feet were swollen for four days, and they tend to swell when he sits in the chair for extended periods of time and requested a physician evaluation.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection,**

	supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	Review of Resident A's medical records read consistent with the facility's physician communication logs thus, there was insufficient evidence to support Resident A lacked medical services. Resident A's spouse was his "Responsible Party" in which she would have privileges to his medical records if requested. Review of the facility's admission contract and observations while on-site revealed the facility maintained an organized program for visitors entering the facility, thus this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

Jessica Rogers 05/03/2023

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 05/19/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section